Correspondence

The Cost of Nontreatment

To THE EDITOR: The recent shooting in Berkeley, California, that resulted in the deaths of two people and injury to several others follows a tragic yet familiar pattern. Every few months the media thrust upon us the image of people with guns terrorizing their hostages or killing at random and offer shallow explanations such as racism, family problems, or availability of weapons.

The one denominator common to all these cases is the presence of a major psychiatric problem.

Over the past 20 years psychiatric services have been dealt three strikes:

- The government has closed the psychiatric hospitals and has failed to replace them with community facilities as planned.
- The private sector has withdrawn from providing care by severely restricting psychiatric coverage in health insurance and creating barriers to access while downgrading the level of care to counseling.
- The courts have effectively limited the scope of care to those patients who do succeed in entering the psychiatric health care system and have increased the cost dramatically.

Today, at a time when psychiatry can offer more than ever before to the seriously mentally ill, these patients are relegated to the jails or to the streets to suffer alone while the public is denied basic protection.

The price paid by society as a result of the dismantling of the psychiatric health care system is a public health matter and can only be addressed by a major overhaul, including the private sector, the legal constraints, and the public care system.

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Are SI Units Dangerous?

To THE EDITOR: Several leading medical journals, including *WJM, JAMA,* and the *New England Journal of Medicine,* have changed their normal reference values from standard American units to Système International (SI) units. A main argument in favor of this change is that the use of moles is more logical than the use of wholly unrelated units.

There is, however, a strong argument in favor of sticking with conventional units: hundreds of thousands of American physicians and health professionals know and can think in their terms. Under the stress of time pressure, mistakes might be made with a wholesale change. A false sense of accuracy is obtained by their use. For example, an SGOT (now called aspartate aminotransferase) level of 7 to 27 Karman units defines the conditions of the assay.[1] The SI value of 119 to 450 nmol per second^{-1} per liter adds a digit of spurious accuracy and fails to give the conditions of the test.[2] The value will vary depending on the concentration of substrate, the pH, and the temperature of the reaction.

I surveyed about 80 members of the South Bay Pathology Society, representing some 30 hospitals, on this issue of SI units. No hospital was using them, and no pathologist was interested in changing to them. Two members volunteered that the change would "cost me my job." Subsequently, I learned that one of two university hospitals represented is giving consideration to the change, although slowly, and far in the future.

In an attempt to determine if a switch might cause confusion, I devised a pair of clinical questions whose answers would be easy if one knew SI units but impossible otherwise. I hoped to show that the use of SI units was potentially dangerous and to provide evidence that might be used to support a switch of journal style back to conventional units. I asked 18 physicians the following questions:

- Patient 1 complained of chronic diarrhea. She was very thin but not wasted. In attempting to determine the presence of malabsorption, a chemistry panel was done, revealing a cholesterol level of 6.45 mmol per liter. Does this result speak for or against malabsorption?
- Patient 2 was placed on total parenteral nutrition. A serum magnesium value was 1.0 mmol per liter. The next day the value was 1.2 mmol per liter. Are the patient's values high, low, or normal?

The correct answer for patient 1 was "against," as an elevated cholesterol level of 252 mg per dl would rarely occur in a patient with malabsorption. The answer for patient 2 was "normal," as the reference range for magnesium in our hospital is 0.8 to 1.3 mEq per liter when not translated into SI units.

For the first question, 11 physicians picked the wrong answer. For the second, 8 selected the correct answer, while 4 guessed "low," and 6 guessed "high." The results are worse than those obtained from chance alone. Obviously, if the reference range had been given, the answers would have been correct. Some hospital computers, however, cannot print all values with reference "normals." The problem typically arises with remote-site printers and with unsophisticated software systems.

American medicine, like American society, is pluralistic and resists administered change. At a time when physicians have enough problems with outside pressures, we should not make more problems for ourselves.

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EDITOR'S NOTE: *Change is a challenge. We have chosen to meet the SI unit challenge by acknowledging the need to join the rest of the world but not to impair patient care at the same time. Therefore, the journal will print both SI units and standard American units. Perhaps we will learn the Système International units by juxtaposition.*

Ciprofloxacin-induced Anaphylactoid Reactions in Patients Infected With the Human Immunodeficiency Virus

To THE EDITOR: Davis and colleagues have described acute anaphylactoid reactions in 15 patients taking oral ciprofloxacin hydrochloride.[1] Adverse reactions followed the initial dose in 14 patients; 1 patient had taken the drug previously. Six patients required admission to hospital despite